Heritage Manor Limited

Astley Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Astley Hall Nursing Home is a residential & nursing home providing care and support for up to 48 people. The home has three separate floors, each of which has separate adapted facilities. One of the floors specialises in providing care to people living with dementia. At the start of our inspection 28 people were using the service.

People's experience of using this service and what we found
People were not always safe, and assessment and review of their associated risks were not robust. People were placed at risk of harm of dehydration, malnutrition and pressure injury as staff knowledge, staff time and records were limited.

Staffing levels impacted on people's care delivery. People told us they had to wait for staff support to go the toilet, others said it took considerable time for staff to answer their call bells. Staff told us they were task focused and did not have quality time to spend with people. There was no clear rationale to demonstrate how staffing levels had been considered against people's individual needs and the constraints of the layout of the building. The registered manager's and provider's reliance on the internal computer system (PCS) was not effective in monitoring staffing levels.

Care and support did not always follow best practice. Staff were not always fully trained, or their understanding and competence checked to ensure they had understood the training and applied this to their practice. People who required support to eat and drink were not always supported to have sufficient nutrients. Alternative food options were not always offered if someone did not like what had been given to them. Where people were losing weight, this was not acted upon in a timely way. Working with other agencies was not always consistently applied. We found examples where external healthcare professionals had not been contacted for advice.

Staff were kind and caring towards people when they spoke with them and we saw staff maintained people's privacy and dignity. However, we saw, and staff told us, they did not have time to spend with people. There were long periods of time where people were sat without support from staff and expressed their boredom.

People were not always supported to follow their interests. For example, some people expressed a wish to go outside for some fresh air, but staff told us and we saw the provider did not have enough staff to enable people to do this safely. Access to the outside areas was not freely available to people unless they were supported by staff members. We saw the Lifestyle, Wellbeing and Activity Coordinator worked well with people and people gave positive feedback about their approach and activities they held for them. However, people told us outside of the Coordinator's working hours they had little to do.

The provider's quality assurance systems and processes were not effective and had not enabled them to

assess, monitor and improve the quality and safety of the service. Staff did not have regular formal supervision to receive feedback on their performance, or constructive feedback on how this might be improved. Records relating to people's care were not always accurate, up-to-date or complete. People's health appointments and outcomes were not always recorded fully or accurately. This meant there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were. Call bell waiting times were not monitored.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 19 June 2018).

Why we inspected
The inspection was prompted in part due to concerns received about people's safety and pressure area care. A decision was made for us to inspect and examine the risks relating to the concerns we had received.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Astley Hall Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety and the leadership of the service at this inspection. You can see what enforcement action we have taken at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Astley Hall Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors on the 25 & 26 April 2022 and two inspectors plus one Specialist Nurse Advisor on 04 May 2022.

Service and service type
Astley Hall Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The manager was going through the registration process and was approved as a registered manager for Astley Hall Nursing Home during our inspection.

Notice of inspection
Days one and three of this inspection were unannounced. At the end of day one we let the provider know we would be returning the following day for a second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and three relatives about their experience of the care provided. We spoke with 14 members of staff including the registered manager, deputy manager, provider's representative, nurses, care staff, housekeeping, chef, administrator and agency care staff. We observed the care people received and reviewed a range of records. This included eight people's care records and multiple medicines records. We looked at three staff files in relation to recruitment and support, and a range of records relating to the management of the service, including audits and checks and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

At the time of writing this report, the provider sent us an action plan which detailed how they are responding to the concerns raised.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection in May 2018, we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People who required support with drinking were at risk of harm of dehydration. We saw examples, where records showed one person who required some assistance to drink had only been offered 180mls of fluid in 24 hours. Inspectors observed a jug of juice from the previous day remained in the room and had not been refreshed, and on one occasion their tray of drinks was out of reach. Clinically based fluid targets had not been calculated for people, so staff could not effectively monitor fluid intake to be assured people were drinking enough to keep them healthy. We raised our concerns with the provider who told us they would take action immediately. We found on our third visit that improvements had been made and people were being offered more to drink, however, we found that clinically based fluid targets had still not been calculated.

● People who required thickened drinks were at risk of choking as staff were not following the prescribed guidelines to ensure drinks were thickened to the correct level for the person's individual need. Staff were also not aware that thickened fluid should be consumed within a certain timeframe before the thickened drink became ineffective. We raised our concerns with the registered manager. On the third day of our visit we found improvements had been made. We did not find any person to be harmed because of this.

● People who required support to eat were at risk of harm of malnutrition. We found that where people were losing weight, action had not been promptly taken to support them. For example, one person had lost 4.8kg is just over three weeks. Records showed that they frequently refused the food offered, but we saw, and we read that no alternative meals had been offered. In addition to this we found staff had not asked the person their food preferences. Where people were losing weight, records stated their food had been fortified with sugar, however this is not a nutritional option to support a healthy diet. External support, for example, from a GP or dietician had not been requested where people were losing significant amounts of weight. We drew this to the attention of the registered manager, but on our third day, we found that referrals for people's weight loss had still not been completed. This continued to place people at risk of harm of malnutrition.

● Where people had sore skin, the assessments of their wounds were inaccurate. For example, where a person had a category two pressure sore, the staff had recorded this as a moisture lesion. Where wounds were deteriorating, monitoring and reviews of their wound care had not robustly taken place. We found where people required repositioning to promote healing or prevent sore skin, this was not always done. On our third day we found repositioning frequency had improved, however we saw people had not always been repositioned sufficiently to fully relieve the pressure area. This placed people at further risk of harm of skin damage.

● There were aspects of the home's fire safety which were not safe. In September 2020 the provider had a comprehensive independent fire service risk assessment take place. We found a number of identified shortfalls within this report had not been actioned. In addition to this Hereford and Worcester fire service inspected in April 2022, and identified work was still required to ensure the building was brought to a

satisfactory standard in the event of a fire. During our inspection we found further areas required addressing, such as a number of fire doors were propped open and unlocked empty rooms held maintenance equipment and paints, which posed a potential fire risk. Assurances were given to us these issues would be addressed immediately.

● We identified other environmental concerns, with wardrobes not always being secured to the wall, uneven paving slabs in the garden, and hoist sling safety checks had not been completed since the end of 2021. Windows restrictors were not in line with the Health and Safety Executive guidance, with people being exposed to harm due to a window seating area only having single pane glass. We found some bedroom windows were also painted shut, meaning the provider could not be assured people had adequate ventilation. One person told us, "I'm very hot, these windows don't open, it's so stuffy! Too hot". Another said, "I asked to move from the top floor as it's baking hot in summer and freezing in winter. The windows didn't open, and I like fresh air". We raised this with the provider's representative on the first day of inspection, and assurances where given that these areas would be addressed promptly.

Using medicines safely

● The provider could not be assured that people received their medication as prescribed. We saw examples where records showed that people did not always have their prescribed creams applied, or that time critical medication was given at the prescribed time.

● Temperature checks had been carried out by staff to ensure the medication rooms were at a safe temperature for medication storage. However, for twelve days in April 2022 the temperature was recorded to be at the maximum temperature for safe storage of medication. The registered manager told us they were considering ways to cool the room or move the medication, however, there were no clear plans for when this would happen, or what action was being taken to mitigate risks in the meantime. Following the inspection the provider told us an air conditioning unit had been installed.

● Staff did not always give people their prescribed thickener as directed. This increased the risk people may experience choking.

● We also found concerns that as staff were not identifying wounds correctly the dressings used were not always appropriate for the wound type.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. On the first two days of our inspection there were no domestic staff working. Throughout the inspection we did not see regular cleaning of high use touchpoint areas. We found the equipment for cleaning to be inappropriately stored, which meant good hygiene practices could not be followed. On our third day we found a bath chair to be dirty. This increased the risk of people experiencing infections.

● On our first day of inspection we found some staff had long painted nails and wore jewellery. This does not promote good infection control. The operations manager confirmed this was not in line with their policy and would be addressed immediately. On the second day of our inspection we found staff continued to have long painted nails and wore jewellery.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We found that some bedrooms did not have any form of ventilation. Should a person require to isolate in their room the provider could not be assured they had adequate fresh air flow for their comfort and to reduce the likelihood of airborne infections.

The provider had failed to ensure risks to people's care was managed in a safe way and failed to ensure the proper and safe management of medicines. The provider had also failed to ensure they had adequately assessed the risk of, and preventing, detecting and controlling the spread of infections. This a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
●At times there were not enough staff on duty to make sure people were safe and received the care and support that they needed. People told us they had to wait for support to go to the bathroom. One person told us, "There's no point using my call bell when I need the toilet, nobody comes. They [staff] are so busy, I try and hold it until they [staff] next come to check on me".
● We saw other examples where people were not having their needs met due to low staffing levels. For example, we found that repositioning was not done for people when required. Staff told us that supporting people with personal care, continence care, food and fluids as well as repositioning meant they did not always meet people's needs. Although there were three care staff working on the ground floor, as most people required two staff for support, this did not always mean timely care was provided.
● There were not always sufficient staff at night to support people, particularly in the event of a fire. On 25 April 2022 records showed there were at least 18 people who required two staff to mobilise them in the event of a fire. Other people living with advanced dementia would require emotional support and staff to be aware of their whereabouts. Yet, there were only four staff scheduled to support 28 people over three floors. The registered manager advised that in the event of a fire staff would begin to move people to a safe space, and then the fire service would be able to support with evacuation. However, the provider must be able to demonstrate that they can safely evacuate people in the event of a fire within their own staff group.
● The provider had low staffing levels across the service provision, including domestic, catering, carers, nurses to activities staff. We saw times where staff were taken from one role to assist with another, which meant some duties were not completed.
● We saw staff worked hard to support people, but they told us they did not have time to sit with people and spend quality time with them. One staff member told us, "It's become mainly task focused care, we do what we need to do and don't really have time for anything else. It's not ideal". Another staff member said, "We don't have time to sit down and have a chat with people. It would be better if we had one extra person on each floor to help out". We observed that people were left alone for long periods of time in the communal areas as staff were busy supporting people in their bedrooms or doing other tasks.
● We found the provider had no systematic approach in place to determine the necessary staffing levels required to support people in the home safely and ensure their needs were met. People were exposed to not getting the care and support they needed when they needed it.

The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed. This is a breach of Regulation 18 (staffing) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● From the recruitment records we sampled; we saw that safe recruitment had taken place.

Visiting in care homes
● The provider was facilitating visits to people living at the home in accordance with current guidance.
● Checks were conducted on professionals visiting the service in accordance with the current COVID-19 guidance.

Systems and processes to safeguard people from the risk of abuse

● While staff recognised some types of abuse, and knew what action they would take if they felt people were exposed to this, we found staff had not identified all types of abuse. The inspection brought to light concerns with people's care needs not being met which had a significant impact on their well-being. However, staff had not escalated their concerns through the providers whistle blowing policy, nor did they recognise the significance of the impact to people.
● Where The CQC had been made aware of a safeguarding concern, the provider had not notified us of this incident.

Learning lessons when things go wrong
● Robust systems were not in place to ensure learning occurred when things went wrong. Opportunities were missed and communication was ineffective at learning from incidents and or complaints to drive improvement.
● Incidents affecting people's health, safety and wellbeing were not always reviewed and thoroughly investigated. We noted the provider's internal quality audits had identified a number of people had lost weight in February and April, but this had not been explored any further. Some people had lost over 5% of their body weight in the last six months and had an underweight body mass index (BMI), but there was no evidence that external medical professional intervention had been requested. For example, referrals to external healthcare or dieticians and robust monitoring and reviews had not taken place. On the third day of our inspection we found referrals for one person had still not been made.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not always received fire safety training in a timely way. Staff had not completed practical fire drills to ensure they were able to evacuate the service in a prompt and safe way. On our third visit the registered manager explained they were discussing fire evacuation with night staff over the next few days.
- Care and support provided to people did not always follow best practice. Staff were not always fully trained, or their competence checked to ensure they had understood the training and applied this to their practice. For example, while nurses had received pressure area care training, they did not always put their knowledge into practice.
- An agency member of staff told us they had not worked at the home before and had not been given an induction to the service, or handover about the people who lived there. They told us they had not used the provider's computerised system before and relied upon the permanent staff member to support them. The permanent staff member told us it was not practical to provide support to 13 people whilst supporting the agency staff member they were working alongside. This placed people at risk of delays in their care being delivered.
- Staff supervision and support had not been consistent. Staff told us had they felt supported by the management team but had not had formal supervision on a regular basis. One member of staff told us, "We don't get formal supervision, it's more ad hoc, but the manager's door is always open if we need advice".
- Staff told us there were times when there was not a good skill mix of staff on duty. For example, newer staff providing support to agency staff who had not worked at the home before. The provider was putting plans in place to ensure their staff group had the training and skills to ensure there was a good skill mix. The provider was actively recruiting new staff into the home.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not effectively supported with eating and drinking enough to keep them healthy.
- People were at risk of dehydration as systems in place were not effective in ensuring people who required support were receiving this.
- Where people required a specific texture of food to support their safety, the food was prepared in the kitchen to ensure it met the correct standards.
- People, relatives and staff told us the quality and variety of food offered was good. People who were independent with eating said they had enough to eat and enjoyed the food offered. People told us most staff knew of their dietary requirements and their likes and dislikes. Two people told us they were given a choice of food to eat during the day; however, we observed one person only being given one option and when they told staff they didn't like the option, they were not offered an alternative.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We observed staff did not always seek people's consent to care and treatment when some people were being moved by staff in the lounge without being spoken with or asked for their consent. We also saw some staff knocked on people's doors and asked for their consent before entering.
● People were at risk of psychological harm as their freedoms were not promoted. The provider had no accurate system in place for monitoring the progress or outcomes of applications for Deprivation of Liberty Safeguards (DoLS) authorisations. We found one person had recently been unsettled and had expressed a wish to leave. Their DoLS authorisation had been applied for in May 2021, but not followed up with the Local Authority, despite an escalation in their behaviour. This meant some people who were unable to consent to their care may be being deprived of their liberty without authorisation from the local authority.
● Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not fully understood by staff. People's human and legal rights were not always understood and respected.

Adapting service, design, decoration to meet people's needs
● Astley Hall is an older, listed building and the floors had many different levels to get to people's bedrooms. Access from the top two floors to the ground floor was via the stairs or a small lift. We saw one person ask to go downstairs but changed their mind when they were about to enter the lift due to its size.
● Facilities and premises were not designed in an accessible way. Private space was not always available for people to spend time with visitors or spend time alone. Gardens and other outdoor spaces were inaccessible for people to use independently. For example, we saw people wanted to go outside; however, staff told us they could not allow people outside as there were trip hazards, such as uneven paths and the garden area was not secure.
● The physical environment had not been adapted to take into consideration the needs to people living with dementia and there was a lack of signage in place to support people to navigate around the home. There were limited signs to help people recognise their own rooms. This meant people could not easily orientate themselves within the home. In addition, there was a lack of interactive or dementia-friendly resources within the home. Clocks around the home were also set to incorrect times. This meant people who are living with dementia or who are not orientated with time could become even more confused.

The provider failed to ensure people's personal preferences, lifestyle and care choices were met. This left people at risk of being deprived of their liberty and human rights. This was a breach of Regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff

working with other agencies to provide consistent, effective, timely care

● We saw some areas of good practice from staff, where people were supported with their mental health to ensure they had the best outcomes. However, we also observed some staff being more task focused due to limited time. One staff member told us, "Our Lifestyle and Wellbeing Coordinator does lots of fun and interesting things with residents, I wish we had more time just to sit and chat with residents as well to get to know them better".

● There was limited evidence in some people's care records of the provider having worked with other agencies to ensure people's needs were met where there had been a change in their presentation.

Supporting people to live healthier lives, access healthcare services and support

● Some people had not always been assisted by staff to have timely access to healthcare services and support. One person had experienced a deterioration in their physical health, but we found no evidence an appropriate referral had been made in response to this.

● Staff supported people to attend health appointments, opticians and dental appointments, so they would remain well.

● Staff were aware of people's upcoming health appointments, and so ensured people were ready and prepared to attend these appointments on time.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Individual staff showed kindness and compassion towards people, however the provider's systems and processes meant that people were not always cared for in a compassionate way.
- People felt staff treated them well. One person said, "They [care staff] are ok. Some I like better than others, but they are rushed off their feet".
- Some people did not always feel empowered to share their views because they were concerned they were being a burden on staff time. One person told us, "They [care staff] are lovely but I don't like bothering them as they are so busy". A third person told us, "I don't see the manager much but they [care staff] work so hard".
- We saw staff did not always have time to support people with their emotional needs. Care staff were busy providing personal care and told us they did not always have time to spend with people. Staff told us they did not always have opportunity to sit and talk and have meaningful conversations with people. This was because the provider's calculated staffing levels meant staff had to work with a task focused approach.
- Relatives we spoke with spoke highly of the staff and felt confident the staff had their family member's best interests at heart but also commented on the impact of staff resources available. One relative told us, "Staff work really hard and do their best, but I worry about [my relative] as they need a lot of support to eat and get comfortable in bed and staff are so busy".

Respecting and promoting people's privacy, dignity and independence

- People we spoke with told us they were treated in a dignified and respectful way by staff, but had to wait for a response from staff if they rang their call bells due to staff being busy. One person told us, "I don't see the point in using my call bell, I sometimes have to wait for up to half hour when I need to go to the toilet."
- The dementia unit did not promote a dementia friendly area, with poor signage and lack of stimulation for people. Due to staffing levels being low, where people wanted to go outside to the gardens this was refused as staff said they could not leave the floor.
- Staff told us they enjoyed working at the home and were keen to care for people in a dignified way. One staff member told us, "I love working with people to give them a better quality of life". Another staff member said, "This is their [people who live at the service] home, they should get to decide how they live for example what time they get up, not what's the easiest for staff".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We found limited evidence of regular care planning reviews with people and their relatives. Where people's needs had changed, care plans were not updated in a timely manner to ensure staff had the information they needed to meet people's needs.
- For new people moving into the home, their preferences were not always sought in a timely manner. For example, we found one person who had lived in the home for six weeks had not been asked for their food preferences despite losing significant weight.
- People who lived with dementia did not always have care personalised to them. We saw, and staff told us, they did not have time to spend with people. This impacted negatively on people. For example, one person told us they wanted to get out of bed into their specially adapted wheelchair for some fresh air, but staff said the person could only tolerate this for a short period of time, so it was best for them to remain in bed. Staff had not considered how this short period of time outside would have been beneficial for the person's mental wellbeing.
- Staff were knowledgeable about some people's choices but did not have the time to support people to fulfil them. For example, they were unable to take people out into the garden when people wished to do so.
- We found for people who had lived at Astley Hall for a longer period of time, staff had developed an understanding of their preferences.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's information and communication needs had not been explored with them, recorded or communicated to staff to promote effective communication. This posed a risk people may feel isolated.
- The provider did not offer information such as care plans in alternative accessible formats to ensure people, including those living with dementia, had information they could access and understand. This increased the risk of poorer outcomes for people.

The provider had failed to recognise people's preferences and needs. This was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● People were not always supported to follow their interests, for example some people expressed a wish to go outside into the garden for some fresh air, but staff told us, and we saw, there were not enough staff to enable people to do this safely.

● It was recognised due to the pandemic, staff had not been able to support people's external social care needs as they had done so previously, due to 'lockdown' and shielding for clinically extremely vulnerable people. However, we saw the Lifestyle and Wellbeing Coordinator worked well with people and people gave positive feedback about their approach, activities they held for them, and the entertainment that had been arranged.

Improving care quality in response to complaints or concerns

● Complaints were responded to in line with the provider's policy. However, we found some missed opportunities for learning and improving practice within the service.

● People and relatives we spoke with told us they knew how to raise a complaint if they needed to.

End of life care and support

● We read comments from relatives expressing their thanks to staff for the support given during this time.

● People had end of life care plans in place but these lacked details about their preferences and wishes. For example, one person had been admitted to the service for end of life care and support, but their care plan remained blank several weeks after admission. The lack of details meant staff may not have the guidance they needed to promote good, person centred care for people at this key stage of their lives.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated good. At this inspection the rating had deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems for ensuring staff remained competent to provide care to people were not robust and staff practice in key areas of care provision was not regularly checked. This included an absence of checks on the competency of nursing staff to manage wounds.
- The provider's systems to monitor quality and safety had failed to identify unsafe environmental issues, including wardrobes not always being secured to the wall and uneven paving slabs in the garden. Also, windows restrictors were not in line with the Health and Safety Executive guidance, with added risk of the potential of people being exposed to harm due to a window seating area only having single pane glass. We raised this with the provider's representative on the first day of inspection, and assurances where given that these areas would be addressed promptly.
- The systems in place to monitor the accuracy of care records failed to identify records relating to people's care were not always accurate, up-to-date or complete. People's health appointments and outcomes were not always recorded fully or accurate. This meant there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were. This increased risk to people, should they require emergency healthcare.
- The registered manager was aware the computerised system for recording people's care was not working as well as required to support good care to people. They told us records could be stored in different parts of the computerised system, making it difficult to get an overview the person's care and to identify any gaps in information, patterns or trends. It had not been made clear to staff where information was to be recorded so that a consistent approach in record keeping could be taken. This increased risk to people, should they require emergency healthcare.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Systems for continuous learning and improving people's care were not effective. For example, an audit was undertaken to review the number of people with weight loss each month, however, no further exploration was undertaken to gain an understanding of why this may be happening. Opportunities to drive through improvements in people's care were missed/not always taken.
- Staff did not have regular supervision, to receive feedback on their performance and constructive

feedback on how this might be improved.

Working in partnership with others

● Systems for working effectively with other organisations with responsibilities for people's care were not always embedded. People's health appointments and outcomes were not always recorded fully or accurately. This meant that there was no clear record of when people were seen by health professionals or what the outcome of their appointments or visits were.

● We found there were occasions where the provider had not requested external health and social care professionals advice and support despite some people losing more than 5% of their body weight and developing pressure ulcers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had not actively sought the views of people, relatives, staff or visiting professionals on the service and how this might be improved. There were no records of feedback surveys or questionnaires having been sent out by the provider to invite feedback on the service.

● We saw limited evidence that individual meetings with people and their relatives were taking place, to involve them in a review of their care needs, provide them with key updates and give them an open forum to raise suggestions or concerns. The registered manager told us these reviews had not been held due to the pandemic but the service was planning on re-introducing these soon.

● The lack of effective quality assurance systems and processes, audits and regular staff meetings meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.

● Staff said they worked well as a team and felt supported by management in their role . One member of staff told us, "One thing I'm proud of; the team. We have moved forward, we were at a point when it was so stressful and at breaking point during the pandemic but we all pulled together and got through it, the team are great, they care about people".

● The fire risk assessment completed in 2020 by an independent external company highlighted multiple areas that required addressing. These concerns were then highlighted again during the Hereford and Worcester fire service inspection in April 2022. Where some actions had been identified from the independent report, these had not been rectified.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to recognise people's preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's personal preferences, lifestyle and care choices were met. This left people at risk of being deprived of their liberty and human rights.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably competent and experienced staff were deployed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to ensure risks to people were being monitored and managed safely. The provider had failed to ensure the proper and safe management of medicines. The provider had failed to ensure they had adequately assessed the risk of, and preventing, detecting and controlling the spread of infections. The premises were not always safe to use for their intended purpose.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure the service was being managed effectively and failed to ensure comprehensive quality and safety monitoring.

The enforcement action we took:

We issued a warning notice